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Prescription Drug Plan Faces Tests

Insurers' Participation Uncertain, Experts Say

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Congress's dramatic pre-dawn votes on Friday to add prescription drug benefits to Medicare were a political milestone, authorizing the biggest expansion of the program since its birth. But health policy analysts say that, even if the House and the Senate are able to resolve differences between their bills, it is far from certain the plan would work.

The drug coverage envisioned by Congress and the White House relies on two kinds of private methods: separate policies solely for drugs, something that does not currently exist, and preferred-provider networks, a health plan that is common among younger people but includes few Medicare patients.

According to policy specialists, industry lobbyists, Wall Street analysts and health care executives, not one company has said publicly that it would sign up for either of these new marriages with Medicare, and the willingness of insurers to take part remains an open question.

"There is no solid commitment to participate," even though lawmakers have been developing the idea of federal drug benefits for years before last week's votes, said Robert L. Laszewski, a Washington-based health policy consultant whose clients include several of the nation's leading health insurers. "That has got to be a big yellow light to what Congress . . . is doing."

Until now, the political and policy debate over Medicare's future has revolved largely around whether the country could afford to help pay for older Americans' medicine, whether the coverage would be good enough and how to achieve the proper balance between the government-run and private aspects of the program. The practical question of whether its 40 million patients could find insurance for drugs, even if Congress wants it, has become increasingly central as a revision moves closer to reality.

Medicare was created in 1965 to provide health insurance for people 65 and older. The government's second-largest program -- surpassed only by Social Security -- it has paid for medicine administered in a hospital but not for prescription drugs that patients buy.

In interviews, industry officials said that, broadly speaking, they are glad the government is working to carve out older markets for them at a time when the nation's population of the elderly is about to soar. Privately, they acknowledge they are unsure, even at this late stage in the government debate, whether signing up Medicare patients would be sound business.

That decision, company executives and lobbyists said, hinges on subtle but crucial details in the legislation. These involve how much they would be paid, how tightly they would be regulated and how much the government would help them if patients' need for medicine -- or pharmaceutical prices -- proved greater than they expected. In some instances, these critical issues are addressed differently in the House and Senate bills. As a result, industry officials said they cannot decide whether to participate before they see what emerges from House-Senate negotiations over the bills scheduled to begin in about a week.

Overlaying these issues is the sour taste Medicare has left with parts of the health care industry because of the program's recent history in enlisting HMOs and other private health plans to accept older patients. Many such plans have dropped out or pared their services, complaining that the government has been stingy and intrusive.

Highmark Inc. is a large Blue Cross Blue Shield plan in western Pennsylvania, with a large population of the elderly, that has always participated in Medicare. It has run a Medicare HMO for several years, and has just started a preferred-provider organization (PPO) through Medicare.

Despite that long association, Highmark is not sure it wants to offer the drug benefits Congress is seeking. "We are going to give it every hard look," said Bruce R. Hironimus, Highmark's vice president of government affairs. "But we are not at the position we can make a business determination today."

Others are much less receptive. "I don't think anyone in the industry has any confidence," said one insurance source who, like many interviewed for this story, spoke of her reservations on the condition of anonymity for fear of antagonizing lawmakers while the legislation is taking shape.

Both the House and Senate bills would devote an additional \$400 billion to Medicare over the next decade, mainly for the new drug benefits. The benefits would be voluntary, and unlike the original Medicare program, which is administered by a federal agency, the idea behind the legislation is for patients to purchase drug coverage from two kinds of private companies.

Patients who want to stay in the traditional fee-for-service part of Medicare, as nearly nine out of 10 choose to do today, could buy coverage through a separate insurance policy. Or patients could sign up to get coverage from a private health plan, which would oversee the rest of their health care as well.

The drug benefit would be the same either way and would be subsidized by the government. The legislation varies in specifics, but, in general, both measures would require patients to pay a premium each month and a yearly deductible before the government subsidized their drug spending up to a certain limit. After they reached that limit -- which differs in each bill -- the coverage would stop, except for a relatively small portion of older people who have extremely large, or "catastrophic," pharmaceutical expenses.

The Senate has tried to hedge against the possibility that private companies might balk by including in its legislation a promise that the government-run part of Medicare would offer a drug benefit anywhere in the country that patients do not have two private-sector choices. The House legislation contains no such guarantee.

The industry has different reasons for its qualms about drug-only insurance and about drug coverage as part of private health care plans.

One difficulty is that Congress anticipates that the separate drug policies would be offered by companies that are pharmacy benefit managers, known as PBMs, as well as by existing health insurance companies.

Dan Mendelson, a former Clinton administration budget official who now works as a health care consultant, including to pharmacy benefit managers, said: "This concept of drug-only insurance does not exist in nature." Mendelson recalled that a few PBMs briefly offered such policies in the mid-1990s but stopped after discovering they could not make a profit.

For PBMs, such an arrangement conflicts with a tradition in which they administer drug benefits and

work to keep down costs, but do not shoulder insurance risks.

Some of those companies are completely opposed to assuming those risks; others are open to them but wary. Barrett A. Toan, chairman and chief executive of Express Scripts Inc., one of the nation's largest PBMs, said the idea could be "workable," but only if the government gives the companies enough freedom to employ various tools to constrain their expenses.

Toan and other industry sources are highly critical of two provisions in the Senate bill that limit that freedom. One would require the new drug insurance policies to allow patients to receive a 90-day supply of pills from a pharmacy, a convenience typically allowed by PBMs only if patients order their medicine by mail. The other measure would require PBMs to disclose to the Departments of Justice and Health and Human Services the discounted prices they have negotiated with drug manufacturers, a provision the companies say would make those negotiations more difficult.

Health insurance companies, already accustomed to the risk of higher-than-expected costs, also have doubts about the plans. One of the main reasons is that Medicare patients would decide on their own whether to buy the coverage. Ordinarily, insurance companies offset the cost of their most expensive patients with those who use less care. But under a voluntary drug benefit, executives and policy analysts predict, the patients most prone to sign up would be the ones who use a lot of medicine.

"Am I going to set my price . . . and then the people whose drug spending is more than that will buy the product and people whose drug spending is less won't?" asked Donald A. Young, president of the Health Insurance Association of America.

Both the House and Senate, in slightly different ways, seek to cushion such financial risk, at least temporarily. But questions linger within the industry over whether those attempts go far enough.

Companies that run preferred-provider networks, meanwhile, are also skeptical, partly because of the managed care industry's disappointment over Medicare's relationship with HMOs in Medi-care+Choice, a part of the program created in 1997.

The Bush administration has appeared sensitive to that difficult history, encouraging Congress to designate PPOs, not HMOs (which operate a more restrictive version of managed care), as the basis for redesigning the program. Thomas A. Scully, the administration's top Medicare official, said at a recent Senate hearing that PPOs were "fundamentally different" than HMOs, adding that "we believe there is going to be intense competition" to take part in a redesigned program.

The administration draws hope from a fledgling experiment with preferred-provider organizations that since last winter has led 16 companies that run PPOs to sign up 66,000 Medicare patients, less than two-tenths of 1 percent of the program's beneficiaries.

Health plan officials, however, said they are uncomfortable with an aspect of the House and Senate legislation, that is not part of the experiment, that would require them to compete in 10 large regions of the country -- areas larger than their current markets. And even though Congress would add money to rural communities, health plans say it remains difficult to sign affordable contracts with doctors and hospitals in sparsely populated parts of the country.

Health plans and their trade association have more optimism about the House bill, which would give them more money more quickly than the Senate version.

Still, an insurance industry source said: "We are all kind of scratching our head, saying, 'We don't know how we are going to do this.' "

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